DOCUMENT RESUME

ED 171 872 UD 019 545

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TITLE Public Policy and Minority Health Manpower: Linking Alcohol Drug Abuse and Mental Health Issues to Manpower Resources.
PUB DATE May 78
NOTE 56p.

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS Alcoholism; Drug Abuse; Federal Legislation; *Health Personnel; *Health Services; *Manpower Development; *Manpower Needs; *Mental Health; *Minority Groups; Public Policy

ABSTRACT

This report reviews selected issues related to minority health manpower with a specific focus on mental health, alcohol, and drug abuse programs. Particular attention is given to the public policy that separates treatment for mental health from that of physical health. Reference is made to the confusion that exists in a dual system of health care with respect to caring for different classes of patients. Also the problem of distinguishing mental health from mental illness is described. Mandates issued by Congress to deal with the shortage and maldistribution of quality mental health care resources are discussed. Steps taken by the Federal Government to increase the supply of health professionals including minorities are described. Strategies developed by the National Institute on Drug Abuse, the National Institute of Alcohol Abuse and Alcoholism, and the National Institute of Mental Health to deal with manpower needs and training are also described. Statistics are reported showing the paucity of data on mental health related manpower and recommendations concerning data collection, a national mental health policy and a minority manpower program are made. (Author/EB)

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JUN 12 1979

ED171872

PUBLIC POLICY AND MINORITY HEALTH MANPOWER:
Linking Alcohol, Drug Abuse and Mental Health Issues to Manpower Resources

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This paper is a revised presentation from the National ADAMHA Conference on Minority Group Alcohol, Drug Abuse and Mental Health Issues, May 22-24, 1978 Executive Tower Inn, Denver, Colorado.

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ABSTRACT

Selected issues related to minority health manpower are reviewed with a specific focus on mental health, alcohol, and drug abuse programs. Statistics are reported showing the paucity of data on mental health related manpower.

INTRODUCTION

It is customary in administration, and legend for one to assign impossible tasks to those one would destroy. One must be mentally disturbed to accept such tasks, especially when one has an option not to do so. However, it is almost an impossible task that confronts anyone attempting general brief, but definitive, account of mental health, alcohol and drug manpower. The degree of depression intensifies when one is charged to focus this account on the four targeted minority groups of the Federal Government: Asian, Black and Hispanic Americans and American Indians, in the separate areas of mental health, alcohol and drug abuse. Moreover, the information is incomplete. The quantity of what is done by whom, as well as the quality of what is done to whom in the field of mental health, alcohol and drug abuse is questionable.[26] I will, therefore, attempt nothing more than a review of the literature, and an interpretation of the situation as I see it.

Issues for discussion are presented throughout the paper. Some specific questions and recommendations are included in the summary of this challenging exercise.

ESTABLISHING THE GENERAL FRAMEWORK

Mental Health and Public Policy

Mental health services in the United States constitute a system (or non-system) of care largely distinct from the general health care system. The locale for treatment of mental illness is usually separate from that of physical health. For example, we have community health centers and community mental health centers funded by the Federal government.

We have short-term community hospitals and we have short-term non-psychiatric community hospitals. This duplication of services and facilities is further fragmented by the lack of association with welfare, educational, vocational, and judicial systems. Moreover, the care of the mentally ill has been, historically, a public function. Whereas, care of the physically ill has been, and still remains, largely a private function in the United States.[61]

This observation was reinforced in a 1973 study entitled, Financing Mental Health Care in the United States which stated:

> When one reviews Federal activities which support mental health services and facilities, it is apparent that continuing efforts are needed to improve coordination of programmatic efforts, to include mental health in general health programs without specific discrimination, and to insure Federal leadership and financial support for mental health program innovation and for the development of a basic national capacity to deal with mental health issues (p. 70).

The roles of the public and private sectors of the nation's economy appear to be reversed in the field of mental health, alcoholism and drug abuse. This situation constitutes an area of public policy research that goes beyond the scope of this paper. This may also account for the lack of genuine concern about the supply and type of mental health workers (psychiatrists excluded) in this country.[98]

Yet, this public/private dichotomy reinforces the dual system of health care in mental health as in physical health.[52, 77, 42, 10, 74] Not only is there a dual system of health care with respect to caring for different classes of patients,[103] there is also the more fundamental problem of distinguishing mental health from mental illness[24] and the resulting conflict among professionals themselves.

Notwithstanding, there are difficulties in establishing a clear-cut and coherent policy pertaining to the identification, etiology and care of mental illness problems and mental health problems, because the distinction between the two remain cloudy in the professional community.[11] These murky waters create problems in an assessment of demand and supply for mental health workers. When the focus shifts from treatment to prevention and community focus, the manpower requirements are less clear. "Basic to any understanding of strategies and prevention is the awareness that this is an exceptionally undisciplined area of concern."[11] As a result, confusion and lack of agreement also reign in official procedures. Although for legal purposes, society has seen a need to define mental illness and health, mental competence, fitness to stand trial, and dangerous behavior. Since behavioral knowledge of such concepts is deficient, the application is deficient. The application becomes ambiguous and inconsistent.[50] However, there seems to be considerable consensus that even though experts cannot agree on such concepts, policy-makers must attempt to grasp these concepts. For these are issues to which they cannot remain oblivious.[16] The skepticism of policy-makers may manifest itself in this observation on "The Political Language of the Helping Professions."

> As any society grows more frustrating and more alienating for a larger proportion of its inhabitants, more behaviors are inevitably labeled deviant and more people have good reason to experience themselves as unfulfilled and repressed. Such a society can survive, and maintain its frustrating institutions, only as long as it is possible to manipulate the discontented into conformity and docility and to isolate or incarcerate those who refuse to be "rehabilitated." The helping professions are the most effective contemporary agents of social conformity and isolation. In playing the political role they undergird the entire political structure, yet are largely spared from self-criticism, and even from political observation through a special symbolic language.[15]

Does this imply that the psychiatrist, social worker, teacher, psychologist, lawyer, and minister are regulating the poor,[56] or "projecting mechanisms of unconscious, preconscious," or intentional processes of institutional racism?[75] The role of the psychiatrist in the college setting can be that of a double agent: A medicine man and "an interpreter of moral rules and an enforcer of social laws and expectations."[44, 71] This role of the psychiatrist and that of other members of the helping professions may be to control and contain racism/ethnic minorities in order to assure conformity to social laws. Could this be an alternative hypothesis explaining the dearth of minority health manpower?

EXPANDED MENTAL HEALTH MANPOWER REQUIREMENTS

Title III of Public Law 94-63 is the Community Mental Health Centers Amendments of 1975. Section 302 of this law sets forth several Congressional findings. One of these findings is that there is currently a shortage and maldistribution of quality mental health care resources in this nation.

Section 201 of PL 94-63 also mandates an increase in the scope of services to be provided by community mental health centers. This mandate will increase the requirements for quality mental health manpower upon an already short supply of mental health resources. Unless, however, there is a substantial increase in productivity of existing resources and a major re-distribution of existing manpower resources.

Prior to the 1975 amendments, only five services were mandated to community mental health centers: inpatient. outpatient, partial hospitalization, emergency, and consultation and education. In addition to these services, seven others have been added: Day care and other partial hospitalization services; programs of specialized services for the mental health of children and of the elderly;

assistance to courts and other public agencies in the screening of the center's catchment area residents who are being considered for referral to a state mental health facility for inpatient treatment to determine if they should be so referred, providing, where appropriate, treatment of persons at a community health center as an alternative to inpatient treatment at a state facility; follow-up care provision for catchment area residents who have been discharged from a mental health facility; and a program of transitional halfway house services for mentally ill individuals who are residents of its catchment area and who have been discharged from a mental health facility.

Community mental health centers must also provide, when needed, a program for the prevention and treatment of alcoholism and alcohol abuse, as well as for the rehabilitation of alcohol abusers and alcoholics. If there is a need, centers must provide a program for the prevention and treatment of drug addiction and abuse and other drug dependency problems.

With this new legislative mandate and the increased visits to providers for mental health services, we can expect a continuous demand for mental health, alcoholic and drug abuse manpower. In addition, the problems of family life, work life, social environment, and physical environment affecting the minority individual requires the care, treatment and health education of minority mental health, alcohol and drug abuse workers.[22] However, there have been some attempts to address, not remedy, these concerns.

SELECTED HEALTH MANPOWER ISSUES

The problem of providing adequate and continual growth with regard to the volume of health manpower, properly distributed both regionally and among health occupations, has been a central concern of many policy-makers, health professionals, and manpower researchers for some time. Unfortunately, the concern for the volume of minority health manpower on a national basis is not a major priority of many policy-makers and health professionals. [9, 16]

Over the past several years the Federal government has undertaken a series of important steps to increase the supply of health professionals including minorities. These steps include programs under the Manpower Development and Training Act (1962), the Vocational Training Act (1963), the Health Professions Educational Assistance Act of 1963, the Nurse Training Acts of 1964 and 1975, etc., and most recently, the Health Professions Educational Assistance Act of 1976. We have also observed the establishment of: The President's Commission on Mental Health; the President's Committee on Health Manpower; an Office of Health Resources Opportunity (HRA); and a Center for minority Group Mental Health Programs (NIMH), among others.

The Health Planning and Resources Development Act of 1974 (PL 93-641), and the high probability for a national health insurance or national health service for this country have added another dimension to the requirements for health manpower.

For years the efforts of the Federal government have focused on the shortage of physicians and training of more professionals. While the supply of these professionals have increased, the geographic maldistribution and the overspecialization of physicians have persisted. This maldistribution of

of physicians and other health providers tends to effect rural-farm and inner-city communities where nonwhites tend to live. [85,86]

The Health Professions Educational Assistance Act of 1976 (PL 94-484), included the first major effort to affect the type and location of medical practice after graduation from medical school. The emphasis in training is on primary care, and on all-expense scholarships in exchange for service in areas where shortages exist. PL 94-484 also provides first-year scholarships for disadvantaged students and gives recipients of such aid priority in receiving shortage-area scholarships. It is expected that both levels of funding for both kinds of scholarships will determine how many graduates go to shortage areas. Although the Federal government has supported recruitment and training of nonwhite health professionals since 1968, the percent of minority health professionals in key health occupations and in policy-making positions does not appear to have increased significantly.[80] Notwithstanding, there have been significant efforts to train and educate allied health professionals. These training needs are also addressed in sections 796-798 of PL 94-484. A new Law, P.L. 95-210, provides for reimbursement under Medicare and Medicaid for physician assistants and nurse practitioners.

It is hoped that more minority students will be able to take advantage of the opportunities for advanced training in the various allied health fields. The paucity of minorities and women in health policy making positions in the various levels and sectors of government, educational institutions, voluntary associations, insurance companies, and the private and voluntary health sectors is appalling.[80]

Another area in which minorities should become more involved is that of certification, licensure and credentialing. Although these procedures can be distinguished to some extent, they all influence the growth and expansion of selected health fields, regardless of their perceived relationship "to improving the quality of health care."[102]

In addition, there are other issues that all monority groups should address: 1) The decrease in the number of minority students attending health profession programs (whether the crux of the problem is one of admissions or getting individuals to apply is subject to some debate), and 2) the inevitability of a national health insurance program in this country one day. What form will this insurance program take? Who will it benefit? And more importantly, who will be included or excluded?

MANPOWER FOR MENTAL HEALTH, ALCOHOL AND DRUG ABUSE SERVICES

Drug Abuse

The National Institute on Drug Abuse (NIDA) has developed a document outlining their manpower and training strategy for "the coming years."[87] The goals of this strategy are:

> 1) To strengthen NIDA's role in providing education and training, technical assistance, research support, and resource development for persons working in the drug abuse field. (2) To increase State's capacities to develop and operate effective programs and provide high quality services in drug abuse interventions, and (3) To encourage the development of professional standards for drug program personnel and the documentation of professional development through experience, training and education.

These worthwhile and admirable goals also call for "suitable modifications to be made to existing data systems in order to provide this vitally important information."[87] We also request that data be collected on racial/ethnic providers and drug abuse related workers with specific emphasis on health services areas of predominantly minority populations.

The NIDA emphasis on continuing education, training and prevention is commendable. The majority of studies on minorities with regard to drug abuse, alcohol and physical health tend to focus on treatment and pathology or on intelligence testing.[12, 27, 21, 54, 64]

Drug Abuse Manpower Needs

After muddling through a broad range of public policy areas and budgetary authorities, NIDA has identified the following areas as having the highest recommended manpower and training priorities: Treatment workers, prevention workers, research and evaluation personnel, policy/planning personnel, and specialized services. The first category emphasizes treatment, training and professional development of frontline workers, especially ex-addicts.

The second category emphasizes prevention through the use of workers in community/alternative programs, then drug educators and school counselors. Category three, places emphasis on program evaluators and researchers. Category four, as indicated, emphasizes policy makers and policy planners. The last category, specialized services, places emphasis on volunteers, criminal justice treatment workers, and international treatment/prevention personnel. Nevertheless, according to the Manpower and Training Branch, NIDA, "there is no significant shortage of persons available for employment in drug abuse." [87]

Treatment Manpower Needs

The 1977 NIDA Manpower and Training Administrative Report breaks our manpower needs by priority categories. The treatment category includes the following group of workers: Volunteers, treatment workers in drug abuse programs, treatment workers in related programs, administrators of treatment programs, support staff, and medical professionals. As of March 31, 1976, there were 45,591 paid workers and 14,383 volunteer workers in the treatment category. There were an estimated additional 9,000 persons dealing with corrections, vocational rehabilitation agencies, etc. totalling some 68,975 drug abuse treatment workers. However, there is no indication of the number of racial/ethnic minorities in this category.[87]

Prevention Manpower Needs

Prevention manpower includes persons employed in drug abuse prevention programs, persons coordinating drug abuse prevention activities, and persons providing drug abuse prevention services within the context of a broader program or activity not expressly identified with drug abuse.

It is estimated, by NIDA and the National Education Association, that there are some 37,000 trained prevention resources within U.S. school systems. This is estimated to be some 20,000 persons short, assuming that for each of the 16,730 school districts one administrator, one counselor and one teacher with special preparation in substance abuse is needed.[87]

There are estimated to be some 27,000 community-based (i.e., non-school based) prevention workers for community-based prevention programs plus an additional 35 community specialists with SSA (Single State Agency) directors. With a 20 percent annual turnover rate among community based workers, it is projected by NIDA that there is need for training an additional 17,000 workers.

Other drug abuse manpower needs as estimated by NIDA include some 1290 basic researchers; "an immediate need for recruitment and/or training of over 2000 persons in evaluation"; an immediate need for some 26 new directors of SSAs; and continuing need for training SSA directors and State drug abuse planning coordinators. In addition other trends such as poly/multiple drug use; criminal justice diversion programs; lifestyle and cultural differences; professional development, continuing education, and improving state training capabilities will also demand more specialized training and increased accountability in the provision of drug abuse services on the local, state, regional, and national levels.[87]

Alcohol Issues and Manpower Needs

The primary programs funded by the National Institute of Alcohol Abuse and Alcoholism (NIAAA) deal with treatment: Alcohol treatment centers, problem drinking driver programs, occupational programs, Native American Alcoholism Programs, Public Inebriate Programs, Poverty Programs, and Cross Population Programs.

In calendar year 1976, 315 projects were monitored by NIAAA representing nearly 300,000 clients. There were an additional 39,000 new programs that were not monitored during 1976. These programs focused on Blacks, Spanish migrant workers, women, youth, criminal justice, and the aged.[94]

NIAAA utilization data show that inpatient services are provided to the highest percentage of clients in the Public Inebriate Program. Less than one percent of the clients in the Occupational Program receive inpatient services. Intermediate care is most frequently used on a 24 hour basis. Detoxification care is provided most often in the Public Inebriate and Cross Population Programs. On an outpatient basis, individual and group counseling received the major emphasis in all programs.[94]

Staffing

According to the NIAAA 1976 calendar year report, the largest single group of treatment staff are non-degreed alcoholism counselors. The largest percentage of staff members with Masters Degrees (19.9 percent) was in the Occupational Projects.[94]

The type of staff providing service in NIAAA programs include psychiatrists, registered nurses, LPNs and LVNs, psychologists, social workers, alcoholism counselors, industrial consultants, occupational therapists, recreational therapists, administrators, data managers, clergy, and others. There is no indication of the proportion of the alcohol and alcohol-related workers who are racial/ethnic minorities.[94]

Mental Health Manpower Needs

According to the National Institute of Mental Health (NIMH) data, at least 2.5 percent of the U.S. population in 1975 had "serious mental illness requiring specialized medical care in mental health facilities."[88]

Some 13,409,590 psychiatric visits were recorded in the 1975 Health Interview Survey, representing a 0.6 per capita utilization rate. If third party coverage for mental health services increase, it is estimated that the utilization rate will increase to about 3.5 percent in 1980 and to about 4.0 percent in 1990. Data from the 1977 National Ambulatory Medical Care Survey show 4.5 percent of all patient visits to be related to mental illness.[37]

In attempting to establish an adequate supply of mental health professionals, it would be necessary not only to know the expected productivity level of these professionals, but also to know what constitutes a mental health visit and to whom. For mental health services are also provided by psychologists, psychiatrists, other physicians, social workers, the clergy, nurses, and other health personnel. In 1975, it was estimated that the supply of psychiatrists needed was 26,500 (adult and child); psychologists 22,650; psychiatric social workers 22,650; and psychiatric nurses 39,400. In 1980 and 1990, respectively, the following requirements are projected: psychiatrists, 40,780 and 51,280; psychologists, 30,910 and 38,860; and psychiatric nurses, 55,930 and 70,320.[88]

Although it is not clear from the GEMENAC methodology how these figures were derived, the estimate for psychiatry is based upon an assumption that the productivity level of psychiatrists 1975 was 2,210 visits per person per year. There is no distinction as to wheth hese visits were for inpatient or outpatient services. Derivation of the figures for other workers is not explained.

Minority Manpower in ADAMHA Focused Programs

Although Asian, Black, Native, and Hispanic Americans constitute 20 percent of the total U.S. population, their representation in the mental health profession is consistently less than would be expected given their population proportion, particularly on an aggregate basis.[55]

According to the 1970 U.S. Census data, the latest comprehensive data available: Four percent of the 12,749 persons employed in psychology are minority (312 Blacks, 17 Hispanics, 182 Asian Americans, and no American Indians); 7.2 percent of the 20,084 psychiatrists are minority (356 Blacks, 74 Hispanics, seven American Indians, and 1,000 Asian Americans); 8.7 percent of 6,851 sociologists were minority (345 Blacks, 100 Hispanics, 154 Asian Americans, and no American Indians); 11.3 percent of the 835,797 nurses (not psychiatric nurses only) were minority (65,224 Blacks, 16,846 Hispanics, 1,838 Americans Indians, and 10,698 Asian Americans); and 20.3 percent of the 218,281 social workers (not psychiatric social workers only) were minority (34,169 Blacks, 7,495 Hispanics, 880 American Indians, and 1,860 Asian Americans).[55] As mentioned heretofore, these workers cannot be exclusively considered mental health workers, thereby making it difficult to ascertain an accurate assessment of not only minority mental health manpower, but also all mental health manpower.

A recent 1977 study of "Special Concerns of American Indians," recommended by The President's Commission on Mental Health documented the following national data on American Indians: 13 psychiatrists, two psychiatric nurses, 24 doctoral degrees in social work, and 11 with MA's in psychology.[46] In the Division of Mental Health Programs, Indian Health Service, USDHEW, where there are some 223 positions,[11] American Indian representation is as follows: One American Indian psychiatrist; 12 American Indian social workers; no Indian psychologists; no Indian psychiatric nurses; 31 Indian clerical staff who sometimes act as interpreters; one Indian recreation therapist; and 77 Indian paraprofessionals or mental health technicians.

The supply of American Indian mental health care personnel is conceptually inadequate to meet the current perceived demand for mental health services by the American Indian people.[46]

The paucity of minority mental health workers manifests itself in the mental health administrator category. In a survey of 321 Community Health Centers by NIMH, minorities represented less than seven percent of full-time equivalent staff positions: Only 0.2 percent American Indian; 0.7 percent Asian American; 3.60 percent Black; 2.2 percent Spanish American, and 93.3 percent White.[46] Of the 550 Community Mental Health Centers in the United States, 14 percent (78) of the directors have been identified as minority. Few of these mental health administrators have been trained in administration and management, which is consistent with Feldman's and others findings on the education and background of mental health administrators.[2, 5, 17-19, 28, 32]

There is a need for more well-trained mental health administrators and long term care administrators for nursing homes.[104] There are some turf fights over whether psychiatrists should seek training in administration.[57] Hence, the need for a mental health administrator trained in the principles of Public Administration, Business Administration, and health and disease.[17, 18, 76]

Allied Health Professionals

The allied health professions hold career keys for many minority students. However, with minorities already heavily concentrated in the allied health professions, there is no urgent need to educate and train minorities in this health occupation category. There is a need for more effective utilization of minority allied health professionals in the provision of physical and mental health services to the minority and rural communities.[64, 79]

A more effective utilization of allied health professionals and community workers will increase the productivity level and efficiency of many mental health services operations.[25, 51]

The lack of professional manpower in rural communities has been well documented in a study of the rural programs supported by the National Institute of Mental Health.[64] "Many centers make good use of indigenous professionals, assigning to them functions that used to be restricted to persons with formal professional training and degrees."[64] Furthermore, a few universities have developed a 2-year course leading to an Associate of Arts Degree in Mental Health Technology.

NIMH has been very supportive of the "new career" movement to train personnel drawn from the population it serves, namely those who are "underprivileged due to economics, education or race as these individuals will be more empathetic and responsive to such clients."[1, 6, 14, 30, 39, 40, 66, 97]

Acceptance of allied health professionals by health professionals (in the elitist sense), patients and the community has been mixed in the mental health field as in the total health care "system."[57, 44]

In addition to the scarity of data on the direct minority providers of mental health, drug abuse and alcohol services, there are even fewer minorities engaged in health services research, formulation of health policy, and serving as faculty and other role models for minority students.[55]

In discussion of the problems associated with underrepresentation of minorities in mental health and other health-related activities, L. Miranda and Associates, Inc. of Washington, D. C. have made several observations on this situation. In the categories research, educational instruction, service delivery, and policy formulation they say:

> 1) Generally there is insufficient understanding by members of majority groups of the norms which influence the behaviors of minority subjects or respondents. Gross disturbances of the "natural" situation are created as a result of the majority researchers' (i.e., observers') (perceived) dominant position, status, and visibility. 2) Underrepresentation or absence of minority faculty, deprives minority students of critical role models. 3) Underrepresentation or absence of minority service deliverers deprives minority clients or therapists of their choice, because clients typically prefer working with same race therapists... The delivery of inappropriate treatment often occurs when services are delivered without regard to cultural background of the client. 4) Underrepresentation of minorities among professional associates tends to minimize the pressure on Associations to implement their Affirmative Action plans... the application of minority criteria in accreditation licensure tends to minimized, if not overlooked.[55]

The quest for a proportionate representation of minorities in the health manpower supply pool relative to the total supply is not simply advocated for the provision of health services to minorities by minorities; but also, is advocated toward an effort to meet the potential and actual demand by minorities for such services, and to more efficiently utilize the scarce labor force of the U.S. health system.[53, 35, 78, 79]

Education and Training

The existing supply of minority drug abuse, alcohol and mental health manpower must increase over time in order to maintain the current supply which is already less than need and demand requirements determined by the most cursory methods. Retirement, death, disability, career changes, etc. must also be taken into consideration in projecting the minority mental health manpower requirements. Moreover, something has to be done about the maldistribution problems. Minority health professionals are least likely to locate in rural isolated areas and in the South, where the majority of the Black population and a large portion of the Chicano population reside. As the Special Populations Sub-Panel on Mental Health of Hispanic Americans noted:

> The contemporary trend toward deemphasizing professional manpower and training issues in the health and mental health fields - has been developed on the basis of manpower supply and demand analyses which reveal a current and projected surplus of professionals in related fields. However, as it is often the case, these analyses ignore the patterns of supply, demand, and distribution that are peculiar to special populations such as Hispanic Americans.[58]

Furthermore, the recent and current enrollment of minorities in medical and graduate schools does not provide evidence of positive improvement in the future.[93, 95] "The data suggest, rather, that unless pervasive changes take place in national manpower and training policies, the representation of Hispanics in the mental health discipline will stabilize or even decline in the future."[58] The pattern holds true for American Indians: "As of November 1, 1977, there were only 162 American Indian full-time students enrolled in accredited undergraduate social work programs."46

During the period 1975-77 minority graduate enrollment in selected departments providing training in the related mental health professions were: nursing, 6.5 percent; psychology, 8.0 percent; sociology, 9.9 percent; and social work, 16.3 percent.[55] Examination of enrollment data on minorities in the health professions and allied health professions, generally show that the largest growth in enrollment occurred during the academic years 1968-71. In recent years the minority enrollment is increasing by less than one percent in some cases.[93] This along with the retention problems of many minority students whether for language, cultural, academic, or financial reasons reinforces the negative prospects for the future minority mental health manpower supply pool.[35]

Even among medical students in 1976, psychiatry ranked third from the bottom as the least chosen medical specialty among all medical students and especially minority medical students.[95]

Of course, this may be due to length of residency training, perceived difficulty of the specialty, money problems, and government incentives to study the primary care fields (family practice, internal medicine, and pediatrics). There is also a move afoot to integrate mental health services into primary medical care.[12] This would be a positive step toward a national health policy as long as the social and cultural problems confronting racial/ethnic "disadvantaged" minorities are seriously addressed in this integration process.[9, 74, 85-86, 75. 73, 103, 42. 43]

Alcohol, Drug Abuse and Mental Health Manpower Planning

This paper would be incomplete without a discussion of planning and legislation. Public Laws 94-63, 94-484, 95-215, and 93-641, among others, have established mandates through guidelines and regulations to improve the planning, construction and modernization, health and allied health professions education, and the quality of mental health resources for this nation. Thus, it is legitimate to inquire whether the results (actual and expected) of these programs and activities will contribute more or less to the health goals of Asian, Black, Hispanic Americans, and American Indians. While these groups have some unique differences in terms of health needs (met and unmet), they have their commonality in being neglected by the majority health policy and public policy makers. Yet, the differences in cultures, lifestyles, and dominant geographic residences within these minority groups are sufficient to merit substantive mental health manpower research. These research efforts should be linked to the current need and projected need for physical and mental health services.

For example, if the proportion of health professional and allied health professional workers employed in the health industry was equal in all health occupation categories to their proportion as distinct minority groups in the U.S. population, we would have a substantial increase in American Indians, Blacks, and Hispanics in most all health occupation categories. However, for Asian Americans the education and training would concentrate in most health occupation categories except medicine and health services research. Or should we propose X number of visits (initial and repeat) per person per year for the major providers of services on a per capita basis for each minority population, and establish a goal for a number of health workers necessary to meet this level of "productivity?" This would reduce the health manpower requirements for non-minority health professionals and allied health professionals. The burden of proof shifts. Is this theoretically desirable? The political and economic feasibility is another issue short of a cultural and economic revolution in these United States. Nevertheless, it is feasible to demand that ADAMHA, the U.S. Congress, and other public policy makers stop "schuckin and jivin" with the health status, and subsequent life expectancy of Blacks, Asians, Hispanics, and Indians. The future projections for alcohol, drug abuse and mental health manpower should be weighted heavily toward training and educating these racial/ethnic minorities and women.

Government must continue to make the private market more effective in meeting the health needs of all its citizens, if necessary. It would be preferable to consider a national health service or a national health policy that would eliminate the dis-organization, poor financing, and lack of duplication of health program operations throughout the government and the country.

A national health policy should solve the problems of maldistribution of health resources; seek to "re-finance" the health industry; and establish a "re-redistribution" policy in achieving its welfare goals and in changing what Murry Edelman calls "the political language of the helping professions."[15]

Yet, before any effort at effective mental health manpower planning can take place, the following questions must be answered (for they have been posited before): what is an operational definition of mental health, drug abuse and alcohol abuse? Who provides mental health, drug and alcohol services, in what type, what quantity, and at what level of quality? Can the utilization of mental illness services serve as an operational basis for determining the utilization rate for mental health services?[37] Should the mental health, alcohol, and drug abuse workers employed in teaching administration and research be counted in an equation to determine the need for mental health, drug and alcohol manpower? How high is the cost of mental health, alcohol and drug abuse prevention services relative to each other and the total cost of health care in this country? How large an increase in these services is required to reduce the price of these types of care by a certain amount? What would be the cost to society to bring the number and type of mental health, alcohol, and drug minority professionals and other workers to parity with their population proportion of the U.S. population?

In summary, the following recommendations are made:
(1) ADAMHA should require that statistics and data on race, ethnicity and sex be collected and made readily available on all staff according to each of its functional programs by utilization patterns throughout the nation. (2) A national mental health policy should be developed for the nation or with specificity in the development of a total national health policy. (3) A national minority mental health, alcohol and drug manpower program should be top priority in the manpower training strategies of NIDA, NIAAA, NIMH, and HRA (Health Resources Administration).

(4) Asians, Blacks, Hispanics, and American Indians should be hired in top policy-making positions in order to improve the health manpower planning in all levels of government.

CONCLUSION

As with most perspectives about social and political issues, there are contrary views to all positions. While the argument has been made for the education and training of more racial/ethnic minority professionals and allied health professionals in mental health, alcohol and drug abuse programs, there are other research questions to be answered that would affect this position. For example, under normative organization theory, the tendency to promote the middle class values of the larger society creates special problems in the development of competent racial/ethnic health workers. Should formal educational efforts be curbed in favor of experiental processes? Should the position of the indigenous therapist or lay counselor be further legitimized? Who do members of the helping profession help?

REFERENCES

1. Allen, Sam, and Blanton, Judith: A study of paraprofessionals in mental health. Community Mental Health J. 12: 151, 1976.

2. Austin, Michael J.: Evaluating the training of mental health administrators. Admin. Mental Health 3: 62, 1975.

3. Beck, B. B., and Hinata, L. C.: Mental illness among the Chinese: Myth or reality: J. Social Issues 29; 1973.

4. Berger, Philip, Hamburg, Beatrix, and Hamburg, David: Mental health: progress and problems. Daedalus, 106: 261, 1977.

5. Bissonette, Raymond and Zusman, Jack:Mental health training for the middle manager. Admin. Mental Health 3: 193, 1976. 193.

6. Blank, Marie L.: Meeting the needs of the aged: The social worker in the community mental health center. Public Health Reports 92: 39, 1977.

7. Brickman, Henry R.: Mental health and social change: An ecological perspective, pp. 15-26. In The Social Organization of Health edited by Hans Peter Dreitzel. The Macmillan Co., New York, 1971.

8. Butter, Irene: Health manpower research: A survey. Inquiry 4:5, 1967.

9. Cannon, Mildred S., and Locke, Ben Z.:Being black is detrimental to one's mental health: myth or reality? Phylon 38: 408, 1977.

10. Cantor, Normal L.: The law and poor peoples' access to health care. Law and Contemporary Problems, Health Care Part II, 35 (Autumn 1970), p. 901.

11. Christmas, June J.: Prevention: Problems in decision-making and implementation in mental health and mental retardation services. Bull. N.Y. Acad. Med. 51: 162, 1975.

12. Coleman, Jules V., and Patrick, Donald L.: Integrating mental health services into primary medical care. Med. Care 14: 654, 1976.

13. deMontigny, Lionel H.: American Indian health care delivery today. Proceedings of the National Minority Conference on Human Experimentation, Reston, Virginia, January 6-8, 1976.

14. Davis, Martha S.: Women's liberation groups as a primary preventive mental health strategy. Community Ment. Health J. 13: 219, 1977.

15. Edelman, Murry: The Political language of the helping professions. Politics and Society 4: 295, 1974.

16. Etzioni, Amitai.: Social Science in the White House, Evaluation 4: 13, 1977.

17. Feldman, Saul: Administration in mental health: Issues, problems, and prospects. Bull. Pan American Health Org. 9: 212, 1975.

18. Feldman, Saul: Educating the future mental health executive--A graduate curriculum. Admin. Mental Health (Summer 1974), 74.

19. Feldman, Saul, ed. The Administration of Mental Health Services. Springfield, Illinois: Charles C. Thomas, 1973.

20. Fenninger, Leonard D.: Health manpower and the education of health personnel, Inquiry 10: 56, 1973.

21. Frederick, Calvin J.: Suicide, Homicide, and Alcoholism among American Indians: Guidelines for Help. DHEW Publication No. (ADM) 76-42. Washington, D. C.: U.S. Government Printing Office, 1975.

22. Gary, Lawrence E., ed. Mental Health: A Challenge to the Black Community. Philadelphia, PA: Dorrence and Co., 1978.

23. Giacalone, Joseph J., and Hudson, James I: A health status assessment system for a rural Navajo population. Medical Care 13: 722, 1975.

24. Glasser, William: Mental Health or Mental Illness? New York, Harper & Row, 1970 edition.

25. Greenfield, Harry I.: Allied Health Manpower: Trends and Prospects. Columbia University Press, 1969.

26. Gruenberg, Ernest M.: Limitations of the mental health data base. Medical Care 14: 71, 1976.

27. Harper, Frederick D., and Dawkins, Marvin P.: Alcohol and blacks: Survey of the periodical literature. Br. J. Addict. 71: 327-334, 1976.

28. Harper, Mary S.: Minority issues in nurse manpower planning: education and services, pp. 61-67. In Analysis and Planning for Improved Distribution of Nursing Personnel and Services, Pauline Gingras, Ed. USDHEW, HRA, BHM, Div. of Nursing, Bethesda, Maryland, November 1976. DHEW Publication No. (HRA) 77-3.

29. Haughton, James G.: Can the poor use the present health care system? Inquiry 5: 31, 1968.

30. Hesse, Frank, and Katherine, A.: The paraprofessional as a referral link in the mental health delivery system. Community Ment. Health J. 12: 252, 1976.

31. Hollingshead, A., and Redlich F.: Social Class and Mental Illness: A Community Study. John Wiley & Sons, New York, 1958.

32. Howard, Lawrence C., Henderson, Lenneal J., and Hunt, Deryl G.: Public Administration and Public Policy: A Minority Perspective. Pittsburgh, PA: Public Policy Press, 1977.

33. Howard University: Needs assessments of minority community mental health center directors. Mental Health R&D Center, Institute for Urban Affairs and Research, 1978 (Mimeo).

34. Howard University: Black mental health administrators by state and local government agency. Mental Health R&D Center, Institute for Urban Affairs and Research, 1978 (mimeo).

35. Identification of Problems In Access to Health Services and Health Careers for Asian Americans, Volume II. Final Report to Office of Health Resources Opportunity, HRA, USDHEW, contract No. HRA-230-75-0193, JWK International Corporation, Annandale, Va.

36. Inge, Rosalind: Alcoholism and blacks: A synthesis of findings. Urban League Review 2 : 13, 1976.

37. Jenkins, Joan: Comments on GAO memorandum concerning future supply of psychiatrists. NIMH, February 17 and 27, 1976 (mimeo).

38. Jenkins, Joan: Comparisons of NIMH and HRA projections of future supply and demand for psychiatrists. NIMH, February 18, 1976 (mimeo).

39. Kalafat, John, and Boroto, Daniel: The paraprofessional movement as a paradigm community psychology endeavor. J. Community Psychol. 5:3, 1977.

40. Kane, Robert L., and McConatha, P. Douglas: The men in the middle: A dilemma of minority health workers. Medical Care 13:736, 1975.

41. Kane, Robert L., and Kane, Rosalie A.: Determination of health care expectations among Navajo consumers -- consumers in a federal care system. Medical Care 10: 421, 1972.

42. Kramer, Bernard M.: Racism and mental health as a field of thought and action. In Racism and Mental Health edited by Charles V. Willie et. al., University of Pittsburgh Press, 1973, pp. 3-23.

43. Kuramoto, Ford H., and Parron, Delores: First, rough draft of the Asian/Pacific Workshop. Subcommittee on special populations, President's Commission on Mental Health, December 28, 1977 (mimeo).

44. Lamb, Douglas H., and LaFang, F.: The use of paraprofessionals in university mental health settings: A national survey. Am. J. Community Psychol 5: 321, 1977.

45. Larkins, John R. Alcohol and the Negro: Explosive Issues. Zebulon, N.C.: Record Publishing, 1965.

46. Locke, Patricia: Need for Indians in mental health. Excerpt from Newsletter of the National Center for American Indian and Alaskan Native Mental Health R&D, Portland, Oregon, Winter, 1978, pp. 1, 5.

47. Lott, J.: Asian American employment in DHEW. Office of Asian American Affairs, U.S. Department of Health,Education and Welfare, 1975.

48. Marmor, Theodore: The politics of national health insurance. Executive 3: 20

49. Matsumoto, Y. Scott: Social stress and coronary heart disease in Japan: A hypothesis, pp.123-149. In The Social Organization of Health, ed. by Hans Peter Dreitzel. New York, Macmillan Co.

50. Mechanic, David. Mental Health and Social Policy. Prentice-Hall, Inc., Englewood Cliffs, N.J., 1969.

51. Miller, Donald H.: Community Mental Health. Lexington, Mass: D.C. Heath & Co., 1974.

52. Norman, John C., Medicine in the Ghetto. New York , Appleton-Century-Crofts, 1969.

53. Okun, Arthur M.: Equality and Efficiency: The Big Tradeoff. Washington, D.C., The Brookings Institution, 1975.

54. Padilla, Amado M., and Ruiz, Rene A.: Latino Mental Health: A Review of the Literature. USDHEW, PHS, ADAMHA, NIMH. Washington, D.C.: U.S. Government Printing Office, 1976. DHEW Publication No. (ADM) 76-113.

55. Penick, Benson E.: Evauation of five national minority graduate fellowship programs. Final Technical Report for the Center for Minority Group Mental Health Programs, NIMH. Washington, D.C.: L. Miranda and Associates, January 1978.

56. Piven, Frances F., and Cloward, Richard A.: Regulating the Poor: the Functions of Public Welfare. New York, Vintage Books, 1971.

57. Reim, G.: Alliances of professionals and paraprofessionals: Who owns the turf? Hospital Community Psychiatry 26: 759, 1975.

58. Report to the President's Commission on Mental Health: The special populations sub-panel on mental health of Hispanic Americans, January 16, 1978, (mimeo-draft).

59. Robin, Stanley S., and Wagenfeld, Morton O.: Psychiatrists in community mental health centers. Admin. in Mental Health 4: 29, 1977.

60. Robins, Arthur J.; and Blackburn, Cheryl: Governing Boards In Mental Health: Roles and Training Needs Admin. Mental Health (Summer 1974), 37

61. Roemer, Ruth; Kramer, Charles; and Frink, Jeanne E.: Planning Urban Health Services from Jungle to System. New York Springer Publishing Co., 1975.

62. Roy Littlejohn Associates, Inc.: An Exploratory Study of Distinctive Problems of Alcohol Abuse among Black Americans in Four Communities. Washington, D.C., September 1974.

63. Ruiz, Pedro: A seven-year evaluation of a career-escalation training program for indigenous nonprofessionals. Hos. Commun. Psychiatry 27: 253, 1976.

64. Segal, Julius, Ed.: The Mental Health of Rural America. DHEW Publication No. (ADM) 76-349. Washington, D.C.: U.S. Government Printing Office, 1976.

65. Shin, Yongsack; Jellicka, Davor; and Lee, Everett: Homicide Among Blacks. Phylon 38: 398, 1977.

66. Signell, Karen A.: On a shoestring: A consumer-based source of person power for mental health education. Community Ment. Health J. 12: 342, 1976.

67. Spivack, George: Training evaluation at the Masters level: An experimental program. Evaluation 3: 50, 1976.

68. Sue, Stanley and McKinney, H.: Asian Americans in the community mental health care system. Amer. J. of Orthopsychiatry 45: 111, 1975.

69. Sue, Stanley, and Sue, D.W.: Chinese - American personality and mental health. Amer. J. Orthopsychiatry 1: 36, 1971.

70. Sue, Stanley, and Wagner, N., Eds. Asian Americans: Psychological Perspectives. New York: Science and Behavior Book, Inc. 1973.

71. Szasz, Thomas: The psychiatrist as double agent, pp. 143-160. In Where Medicine Fails edited by Anselm L. Strauss. Transaction Books, 1970.

72. Taube, Carl A., and Redick, Richard W.: Provisional data on patient care episodes in mental health facilities, 1975. U.S. DHEW, ADAMHA, NIMH, Mental Health Statistical Note No. 139, August 1977.

73. Tom, S. : Mental health in the Chinese community of San Francisco. University of California, Los Angeles: Asian-American Studies Center, 1968.

74. Thomas, Alexander, and Sillen, Samuel: Racism and Psychiatry. New York: Brunner/Mazel, Inc., 1972.

75. Thomas, Claudewell S., and Comer, James P.: Racism and mental health services, pp. 165-181. In Racism and Mental Health, Charles V. Willie, et. al., Eds., University of Pittsburgh Press, 1973.

76. Thompson, Theodis: Reflections on public policy and mental health. In Mental Health: A Challenge to the Black Community. Lawrence E. Gary, Ed., Philadelphia, Pa., Dorrance and Co., 1978, pp. 239-293.

77. Thompson, Theodis, and Hicks, Florence J.: Health Policy and Planning in the Urban Community. Ebon Research System, Silver Spring, Md., 1974.

78. Thompson, Theodis: Public policy and affirmative action in public health. Graduate Program in Health Services Administration, Howard University, Washington, D. C., (working paper).

79. Thompson, Theodis: Health careers and the disadvantaged: Doing better or getting worse. Amer. J. Medical Technology 44: 168-172, 1978.

80. Thompson, Theodis, and Barrett, Sharon E.: Occupational racism and sexism in the health industry: A socio-political perspective, forthcoming in Int. J. Health Ser.

81. Tucker, Robert C., and Tucker, Leota M.: The role of paraprofessionals: An administrative dilemma. Admin. Mental Health 3: 114, 1976.

82. U.S. Bureau of the Census: Current Population Reports Series P-20, No. 310, "Persons of spanish origin in the United States: March 1976. U.S. Government Printing Office, Washington, D.C, 1977.

83. U.S. Bureau of the Census: Current Population Reports, P-60, No. 109. Household money income in 1976 and selected social and economic characteristics of households. U.S. Government Printing Office, Washington, D.C., 1978.

84. U.S. Bureau of the Census: Current Population Reports, Series P-20, No. 307. Population profile of the United States: 1976. U.S. Government Printing Office, Washington, D.C., 1977.

85. U.S. Congressional Budget Office: The Role of Aid to Medical, Osteopathic and Dental Students in a New Health Manpower Policy. Staff Working Paper, August 10, 1976.

86. U.S. Congressional Budget Office: Health Differentials Between White and Non White Americans. Washington, D.C.: U.S. Government Printing Office, 1977.

87. U.S.DHEW, ADAMHA: Manpower and Training Strategy, 1977. National Institute on Drug Abuse, Rockville, Maryland.

88. U.S.DHEW, HRA, BHM: Physician manpower requirements. GEMENAC Staff Paper No. 1, September 1, 1977. DHEW Publication No. (HRA) 78-10.

89. U.S. EEOC: Minorities and Women in state and local governments, 1975, Vol. 1, U.S. statistical summary. Washington, D.C.: U.S. Government Printing Office, 1977.

90. U.S. PHS: Health, United States, 1976-77. DHEW Publication No. (HRA) 77-1232. Washington, D. C.: U.S. Government Printing Office.

91. U.S. PHS; An exploratory evaluation of U.S. medical school's efforts to achieve equal representation of minority students. Washington, D.C.: U.S. Government Printing Office, DHEW Publication No. (HRA) 78-635, December 1977.

92. U.S. PHS; Health of the Disadvantaged. CHARTBOOK. HRA, OHRO, September 1977.

93. U.S. PHS: Minorities & Women in the Health Fields. Washington, D.C.: U.S. Government Printing Office, August 1976.

94. U.S. PHS: An overview of seven NIAAA alcoholism treatment programs for calendar year 1976. ADAMHA, NIAAA, Program Analysis and Evaluation Branch, Rockville, Maryland, June, 1977.

95. U.S. PHS: Career choices of the 1976 graduates of U.S. medical schools. Final report of the Association of American Medical Colleges to the Bureau of Health Manpower, Health Resources Administration, contract No. 231-76-0011.

96. U.S. PHS: The supply of health manpower: 1970 profiles and projections to 1990. Washington, D.C.: U.S. Government Printing Office, December 1974.

97. Weaver, Jerry L., and Irui, Lloyd T.:Information about health care providers among urban low-income-minorities. Inquiry 12: 330, 1975.

98. Wellington, Sheila W., and Bellis, Elizabeth C.: Educating the future mental health executive: a public health approach. Admin. Mental Health 4: 44, 1976.

99. Wright, Brenda J., and Isenstein, Vivian R.: Psychological tests and minorities. Washington, D.C.: U.S. Government Printing Office, October, 1975.

100. Yahres, Herbert. A mental health training program for clergymen. In Mental Health Program Reports - 2. National Clearinghouse for Mental Health Information, NIMH, USDHEW, February 1968, pp. 221-229.

101. Yee, Tina Tona: Based on cultural strengths, school primary prevention program for Asian-American Youth. Community Mental Health J. 13: 239, 1977.

102. Yerby, Alonzo S.: Regulation on health manpower. In Controls on Health Care. National Academy of Sciences, Washington, D.C., 1975.

103. Yerby, Alonzo S.: The Problems of medical care for indigent populations. Amer. J. Public Health 60: 1213, 1965.

104. Yolles, Stanley F. The importance of administration in mental health. Admin. Mental Health 3: 43, 1975.